**INCIDENT AND INVESTIGATION REPORT**

This template is intended to assist member businesses develop their own workplace Incident and Investigation Report form. The following information should be used as a guide only. Any wording changes, other than those to insert a business name, may change the context, meaning or purpose of the checklist. We recommend you receive advice from the Victorian Chamber of Commerce and Industry prior to making such changes.

Contacting the Victorian Chamber of Commerce and Industry

The Victorian Chamber’s team of experienced health, safety and wellbeing and workplace relations advisors can assist members with a range of health, safety, wellbeing, employment, human resources and industrial relations issues.

Our experienced health, safety and wellbeing and workplace relations consultants can also provide assistance to both members and non-members on a range of more complex matters for a fee-for-service. The consultants can, among other things, provide health, safety and wellbeing consulting and training to employees, conduct investigations and provide representation at proceedings at the Fair Work Commission.

For assistance or more information, please contact the Advice Line on **(03) 8662 5222.**

**Disclaimer**

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INCIDENT AND INVESTIGATION REPORT

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| This form is to be used to report all accidents/incidents and near misses and to document the investigation into the incident, whether an injury occurred or not. Please complete this form as soon as possible after the incident occurred. Serious incidents and dangerous occurrences, known as ‘Notifiable Incidents’ must be reported to WorkSafe Victoria by the nominated management representative or by HR immediately or as soon as they are notified of the incident. Any injuries must be noted in the injury register. |
|  **PART A: INJURED PERSON’S DETAILS (completed by person involved or by the Manager)** |
| Full name of injured person: |  |  Date of birth |
| Workers address: |  |
| Department & location: |  |
|  Occupation: |  |  Phone: |  |
| ❒ Employee | ❒ Contractor | ❒ Visitor | Company: |
| **DETAILS OF THE INCIDENT**  |
| Date of incident/injury: |  | Time: |  |  am / pm |
| Exact location of incident: |  |
| Activity the worker/contractor was engaged in at time of incident:  |
| **DETAILS OF TREATMENT (if any)**  |
| ❒ Medical Practitioner Details: | ❒ Nil | ❒ First Aid |
| Details of Treatment: | ❒ Hospital Details |
| Was there any time lost  | ❒ Nil | ❒ Yes Days |
| Workers Compensation claim lodged | ❒ Yes | ❒ No |
| Regulator notified | ❒ Yes | ❒ No |
| **CAUSE OF INJURY (tick box)** | **NATURE OF INJURY (tick box)** |
| ❒ | Pushing/pulling | ❒ | Moving plant | ❒ | Cut | ❒ | Fracture |
| ❒ | Trip/slip/fall | ❒ | Biological | ❒ | Bruise  | ❒ | Burn |
| ❒ | Falling object | ❒ | Chemical | ❒ | Sprain/strain | ❒ | Abrasion |
| ❒ | Vehicle | ❒ | Person/Animal | ❒ | Electric Shock  | ❒ | Other - Describe |
| **WHAT BODY PART WAS AFFECTED?** |
| ❒ | Head | ❒ | Hand (right)  | ❒ | Hand (left) | ❒ | Fingers |
| ❒ | Face | ❒ | Knee (right)  | ❒ | Knee (left) | ❒ | Ankle (right) |
| ❒ | Eye (right) | ❒ | Leg (right) | ❒ | Leg (left) | ❒ | Ankle (left) |
| ❒ | Eye (left) | ❒ | Nose | ❒ | Ears | ❒ | Abdomen |
| ❒ | Trunk/Back | ❒ | Foot (right) | ❒ | Foot (left) | ❒ | Other- Describe  |
| ❒ | Neck | ❒ | Arm (right) | ❒ | Arm (left)  |

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| **PART B: THE INCIDENT (completed by Manager in consultation with injured person (and HSR if relevant)** |
| Describe what happened: |
| Were there any witnesses: [please tick]  | ❒ Yes ❒ No (if yes, list names below)  |
| Name: |  | Phone: |  |
| Name: |  | Phone: |  |
| **INCIDENT ANALYSIS**  |
| What factors contributed to the incident: e.g. plant/equipment, work organisation, work methods, worker behaviour and environment? |
| **PREVENTION** |
| What was the IMMEDIATE action taken following the incident? Can the hazard be eliminated?  |
| What action will be taken to prevent a recurrence? Implement controls using the hierarchy of controls. (Refer to the WHS risk management procedure) |
| Corrective action follow up. Check that controls are effective in minimising the risk. |
| **COMPLETION OF INVESTIGATION**  |
| **Incident Investigated by:** | **Name:**  | **Position:**  |
| **Signature:**  | **Date**:  |
| **Worker’s Manager** | **Name:**  | **Position**:  |
| **Signature:**  | **Date:**  |
| **Injured Worker** | **Name:**  | **Position**:  |
| **Signature:**  | **Date:**  |

Return completed form to **[INSERT NAME/DEPARTMENT]**.